ESARVHP
New Hampshire Emergency System for Advance Registration of Volunteer Healthcare Professionals

Physician Registration

PLEASE PRINT CLEARLY

Information in RED is REQUIRED.

1. YOUR LICENSE INFORMATION EXACTLY as it appears on your professional license.

First Name _____

Middle Name _____

Last Name _____ Suffix_____

License # _____ State Issuing License_____Exp. Date (mm/dd/yyyy)_____

2. CONTACT INFORMATION

Mailing Address _____

City_____State/Zip_____Country_____

Primary Phone _____ Alternate Phone_____

Email Address _____

3. CONSENTS AND PLEDGES

Do you consent to NH collecting, using and maintaining your personal information? ❑ YES ❑ NO

Do you pledge the information you have provided is correct? ❑ YES ❑ NO

Do you consent to allow the State of NH to perform a background check on you? ❑ YES ❑ NO

4. DEPLOYMENT PREFERENCES

Are you willing to work under the auspices of the Federal Government during a declared national public health emergency?
❑ YES ❑ NO

5. EMERGENCY CONTACT INFORMATION

Emergency Contact Name _____

Emergency Contact Relationship ❑ Spouse ❑ Co-worker ❑ Relative ❑ Friend ❑ Other

Emergency Contact Home Phone _____Work Phone_____

Email Address _____

6. FOREIGN LANGUAGE/SIGNING SKILLS

Language(s) other than English you speak, read and/or write, or sign _____

_____

Language Fluency ❑ Basic ❑ Conversational ❑ Fluent

American Sign Language Fluency ❑ Basic ❑ Conversational ❑ Fluent

7. DISASTER TRAINING

Type of specialized disaster training received _____

Date completed specialized disaster training (mm/dd/yyyy) _____

Training Institution that offered disaster training _____

Date specialized disaster training certification expires, if any (mm/dd/yyyy) _____

8. SPECIALIZED TRAINING YOU HAVE HAD

❑ ACLS ❑ ADLS ❑ BCLS/CPR ❑ BDLS ❑ CCRN ❑ CEN ❑ EMT ❑ EMT: B / I / P

❑ ENPC ❑ First Aid ❑ HAZ-MAT Decon ❑ HEICS ❑ ICS #_____ ❑ NIMS

❑ PALS ❑ Red Cross DSHR #_____ ❑ TNCC ❑ Wilderness First Responder

❑ Military Training (specify) _____

_____

_____

❑ Other Training (specify) _____

_____

_____

9. OTHER VOLUNTEER ORGANIZATIONS YOU BELONG TO

❑ American Red Cross
❑ Civil Air Patrol
❑ Community Emergency Response Team
❑ Disaster Behavioral Health Response Team
❑ Disaster Medical Assistance
❑ Medical Response Corps
❑ Military Reserve
❑ National Nurse Response Team
❑ NH Public Health Network
❑ NH Strike Team
❑ State Citizens Corps Council
❑ Other (specify) _____

10. SPECIALTY If several specialties, enter one only.
*Enter information exactly as it appears on specialty certification/registration

First Name* _____

Middle Name or Initial* _____

Last Name* _____

Title(s)* _____

Certification Type ❑ ABAI ❑ ABA ❑ ABCRS ❑ ABD ❑ ABEM ❑ ABFM ❑ ABIM ❑ ABMG ❑ ABNS ❑ ABNM ❑ ABOG ❑ ABO ❑ ABOS ❑ ABOot ❑ ABP ❑ American Board of Pediatrics ❑ ABPMR ❑ ABPS ❑ ABPM ❑ ABPN ❑ Radiology ❑ ABS ❑ ABTS ❑ ABU

Area of specialty practice ❑ Allergy & Immunology ❑ Anesthesiology ❑ Colon & Rectal Surgery ❑ Dermatology ❑ Emergency Medicine ❑ Family Medicine ❑ Internal Medicine ❑ Clinical Biochemical Genetics ❑ Neurological Surgery ❑ Nuclear Medicine ❑ Obstetrics & Gynecology ❑ Ophthalmology ❑ Orthopedic Surgery ❑ Otolaryngology ❑ Anatomic Pathology ❑ Anatomic Pathology/Clinical Pathology ❑ Clinical Pathology ❑ Pediatrics ❑ Physical Medicine & Rehabilitation ❑ Plastic Surgery ❑ Aerospace Medicine ❑ Occupational Medicine ❑ Public Health & Gen Preventative Med. ❑ Psychiatry ❑ Neurology ❑ Neur Spec Qual Clin Neurophys & Pain Med ❑ Child Neurology ❑ Vascular Neurology ❑ Diagnostic Radiology ❑ Radiation Oncology ❑ Radiological Physics ❑ Surgery ❑ Vascular Surgery ❑ Thoracic Surgery ❑ Urology

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Specialty Certification Number _____ Expiration Date (mm/dd/yyyy)_____

11. HOSPITAL Required to assign ESAR-VHP credential level allowing you to work in a hospital.

Name of hospital where you primarily practice _____

Hospital City, State _____

What specialty do you practice in this hospital? _____

12. PEER REFERENCE Required to assign ESAR-VHP credential level for those not practicing in a hospital.

Are you a private practitioner, i.e. not currently practicing in a hospital setting? ❑ Yes ❑ No *If No, skip to Clinically Active*

Professional Peer's Name _____

Peer's Email _____

Peer's Phone (eg: 5555555555) _____

Peer's City, State _____

13. CLINICALLY ACTIVE Required to assign ESAR-VHP credential level if not currently practicing in a hospital setting.
* Where you practice in an outpatient or other non-hospital setting

Clinical Supervisor's Name _____

Clinical Supervisor's Email _____

Clinical Supervisor's Phone (eg: 5555555555) _____

Facility Name* _____

Facility City, State* _____

14. RECORD OF ADVERSE ACTIONS
*Are there any adverse actions or restrictions regarding license in any state? ❑ Yes ❑ No

Information in RED is REQUIRED.

15. DEA REGISTRATION *Enter information exactly as it appears on DEA registration.

First Name* _____

Middle Name or Initial* _____

Last Name* _____

Title(s)*_____

DEA Registration Number _____Expiration Date (mm/dd/yyyy)_____

PRINT & MAIL ALL PAGES OF THIS FORM TO:

Curtis Metzger
Hospital Preparedness, Medical Reserve Corps, & ESAR-VHP Coordinator
NH HOMELAND SECURITY & EMERGENCY MANAGEMENT
33 Hazen Drive
Concord, NH 03305

THANK YOU FOR YOUR WILLINGNESS TO VOLUNTEER!